At laparotomy, a biopsy specimen of an omental node showed a Burkitt's-like lymphoma. The patient was treated with combination chemotherapy (CHOP) and remains in a remission.

Of interest, both of our patients engaged in homosexual relations with numerous partners over many years. In addition, each experimented with various street drugs. Cytomegalovirus and Epstein-Barr virus titers were elevated in both of our patients, though no further studies were carried out.

Based on the report of Ziegler and associates, as well as the additional cases observed by us, it appears that a Burkitt's-like lymphoma may occur in homosexual men. Further investigations are needed to define risk factors and develop suitable screening methods.

FRED P. ROSENFELT, MD
BARRY E. ROSENBLOOM, MD
IRWIN M. WEINSTEIN, MD
Cedars-Sinai Medical Center
Los Angeles

REFERENCES

1. Friedman-Kein AE, Lavbenstein LJ, Rubinstein P, et al: Disseminated Kaposi's sarcoma in homosexual men. Ann Intern Med 1982; 96:693-700
2. Ziegler JL, Miner RC, Rosenbaum E, et al: Outbreak of Burkitt's-like lymphoma in homosexual men. Lancet 1982; 2:631

California Legislation Regarding Patients With Breast Cancer

TO THE EDITOR: On October 9, 1982, a symposium titled "The Current Management of Early Breast Cancer," sponsored by Western Medical Center, St. Joseph's Hospital, and the Clinical Oncology Service of the University of California, Irvine, California College of Medicine, was held in Anaheim, California. It was evident that the best available data on treatment of breast cancer are retrospective and could be used to support widely divergent views of the basic biology and appropriate clinical approach to the disease. At the same conference a new California law requiring that physicians discuss a list of specific diagnostic and treatment options with their patients with breast cancer was discussed. However, physicians have not been provided with materials or directives for their presentation to a patient. The Honorable David Roberti, state senator and author of the law, described its origin: a woman disagreed with her physician that she needed a mastectomy, signed out of the hospital, read extensively about the disease, decided to receive radioactive implants and has subsequently done well after an unspecified period of time.

The long-range implications of legislation influencing medical practice were alluded to at the symposium. Not discussed, however, were its potential adverse effects on physician-patient communication and rapport. True, the law will protect inquisitive patients from poorly informed or inflexible physicians. However, some patients react to the news of breast cancer with shock, fear and disbelief. Overly anxious patients, hoping that their physicians will resolve uncertainties and provide firm guidance, may be immobilized by the presentation of conflicting alternatives at a time when their ability or willingness to assimilate it is limited.

Several guiding principles may help physicians in this situation. First, physicians should reassure their patients with newly diagnosed breast cancer that disagreement about treatment does not imply lack of hope and that referral to multiple specialists does not imply loss or dilution of the primary doctor-patient relationship. Second, patients who do not spontaneously request information or discuss alternatives should be encouraged in a nondirective manner to share their experiences, beliefs and fears about cancer and its treatment. In this way patients may be helped to formulate the questions that the law requests we answer, and by asking them they will indicate the proper time to present the materials. Finally, patients who become anxious when you provide the materials should be reassured that you will take as active a role as necessary in helping them decide how to proceed.

GEOFFREY H. GORDON, MD
Departments of Medicine and Psychiatry
University of California, Irvine-
Long Beach Medical Program
Veterans Administration Medical Center
Long Beach, California

Pulmonary Effects of Intestinal Parasites

TO THE EDITOR: During a recent one-month tour of duty at the Lyndon B. Johnson Tropical Medical Center in American Samoa, another visitor, a radiologist, showed me x-ray films of 15 children with chronic chest infiltrates. These occurred primarily in the right middle lobe and perihilar regions. In some of the children repeated x-ray studies had been done over two years showing some shifting patterns, but no resolution of pneumonia. Three had significant eosinophilia noted in their charts. In all of the children chronic coughing or wheezing had been noted. Antibiotics had had no effect.

My immediate conclusion was that most of these children were suffering from the larval migrans effects of intestinal parasites. The larvae of intestinal helminths develop in the lungs where they cause direct irritant and obstructive effects, while the worms themselves may be highly allergenic.[1] In fact, on examination of a single stool specimen for each child, seven contained eggs of either *Ascaris* or hookworms. Later specimens from the other children may show positive results on testing as larvae mature and move to the intestines. Another possible cause, pulmonary effects of filaria,[2] was not investigated during my stay. Approximately a third of the children in the outpatient department presenting with wheezing or coughing that had lasted longer than two weeks were also found to have helminth eggs in a single stool specimen during the one-month period.

These cases reminded me of an old teaching, "All that wheezes is not intrinsic asthma." In the West, where we see many patients from the Far East, Pacific and Central American regions where helminths are highly endemic, it would be well for us to remember to check for the presence of these parasites in new immigrants who wheeze, cough chronically or have

persistent pneumonia. The parasites are also found in the United States, especially the southeast.[3] It would not be unreasonable to examine a stool specimen of any difficult to manage asthmatic patient, especially if there is any indication of chronic changes on x-ray studies.

Unfortunately, since larvae may be present in the lungs with no worms in the intestine, both diagnosis and treatment may require close follow-up checks. Mebendazole (Vermox), which is the best initial drug for helminths,[3,4] is poorly absorbed systemically.[5] Hence, one must treat the patient symptomatically and then in approximately two months, when larvae have left the lungs, retreatment with mebendazole should eliminate the worms unless reinfection occurs. Then the patient should be symptom free and use of other medicines such as bronchodilators can be withdrawn.

JOHN M. GOLDENRING, MD, MPH
Research Fellow
Adolescent Medicine
Children's Hospital of Los Angeles
Los Angeles

REFERENCES

1. Jelliffe DB, Jelliffe EFP: Intestinal helminths, *In* Jelliffe DB, Stanfield JP (Eds): Diseases of Children in the Subtropics and Tropics. London, E. Arnold Publ, 1979, pp 515-535
2. Kershaw WE: Filariasis and dracontiasis, *In* Jelliffe DB, Stanfield JP (Eds): Diseases of Children in the Subtropics and Tropics. London, E. Arnold Publ, 1979, pp 915-927
3. Blumenthal DS: Intestinal nematodes in the United States. N Engl J Med 297(26):1437-4139
4. Drugs for Parasitic Infections: Med Let Dr & Therap 1978; 20(3): 17-28
5. Wolfe MS, Wershing JM: Mebendazole treatment of trichuriasis and ascariasis in Bahamian children. JAMA 1975; 230(10):1408-1411

Hospice Care

TO THE EDITOR: "Commentary From Coeur d'Alene: Care for Terminally Ill Patients" by E. R. W. Fox, MD,[1] reflects the growing awareness among physicians of the benefits of hospice care and the entire hospice movement.[2] The unique concerns of the hospice movement are the management of terminally ill patients in such a way that they live until they die, that the family lives with them as they are dying and that the family members go on living after their loved one dies. The most significant feature and concerns of hospice care include not only expert symptom management and pain control, but attention to psychological, sociological, spiritual and financial concerns. No professional group possesses all of the knowledge required to deliver hospice care; these comprehensive care measures can only be delivered by a truly multidisciplinary team.

The National Hospice Organization (NHO), with cooperation from national health care organizations and leaders in the field of hospice care, has been working diligently to answer the questions related to quality of care, facilities and personnel that Dr Fox mentions in the latter part of his commentary. The standard documents that currently guide hospice care can be obtained by writing to the NHO.

Dr Fox states that "the medical profession has joined in giving tacit support to the hospice movement." We need to give more than tacit support. We must take a very active role and provide leadership for the hospice movement in this country. In 1980 the Association of Hospice Physicians (1211 A. Dolly Madison Boulevard, McLean, VA 22101) was formed. I strongly encourage all physicians who want to learn more about the hospice movement and its principles of hospice care to join that organization.

TY HONGLADAROM, MD
Member, Board of Directors
National Hospice Organization representing the Pacific Northwest Region
Virginia Mason Medical Center
Seattle

REFERENCES

1. Fox ERW: Commentary from Coeur d'Alene: Care for terminally ill patients (Commentary). West J Med 1982 Oct; 137:359-360
2. What Is Hospice?, 2nd Ed. Seattle, WA 98104, Cancer Information Service, Fred Hutchinson Cancer Research Center, 1981 (one copy free)

Preoperative Medical Evaluation

TO THE EDITOR: I enjoyed the article by Drs Elliot, Linz and Kane in the October issue.[1] It was succinct, brief and uncomplicated by excessively technical considerations.

One sentence caught my eye: "In this paper, we review the recent literature and provide an approach to perioperative medical management based on our experience with a general medicine consultation service at a university hospital." Does the sentence imply that patients going to surgery routinely receive a general medicine consultation? It behooves all physicians to sharpen their skills with regard to proper history-taking and performance of physical examinations, especially before any high-risk procedure, be it an operation, endoscopy or other relatively invasive procedure. All physicians, including ophthalmologists, orthopedists and psychiatrists, should have at least the basic knowledge contained in the article published by Drs Elliot, Linz and Kane and be able to apply it. Is it really necessary to "farm out" preoperative evaluation to another physician when the considerations outlined in the article should be clear to all MD's?

RALPH R. OCAMPO, MD
President, San Diego County Medical Society
San Diego

REFERENCE

1. Elliot DL, Linz DH, Kane JA: Medical evaluation before operation. West J Med 1982 Oct; 137:351-358